PRINTED: 02/10/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155596		B. WING		C 02/04/2011	
<del>-</del>	OVIDER OR SUPPLIER		<b>!</b>	50	EET ADDRESS, CITY, STATE, ZIP CODE O N WILLIAMS ST NGOLA, IN: 46703		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMME	NTS	F	000			,
	IN00085379.	the Investigation of Complaint					· (-
·	Federal/State def	85379 - Substantiated, riciencies related to the ted at F272, F280, and F323.					
арр 313111 pm	Survey dates: Fe Facility number: Provider number: AIM number: 100 Survey team: Ar Census bed type SNF: 5 SNF/NF: 62 Total: 67 Census payor ty Medicare: 5 Medicaid: 39 Other: 23 Total: 67	000474 : 155596 )290510 nn Armey, RN			This Plan of Correction is the credible allegation of complete Preparation and /or execution plan of correction does not a admission or agreement by provider of the truth of the fileged or conclusions set for statement of deficienceis. To correction is prepared and/of solely because it is required provisions of federal and statement of deficience and statement of deficience and/of solely because it is required provisions of federal and statement of deficience and deficien	iance. on of this constitute the facts althin the he plan of r executed by the ate law.	
	Sample: 3 This deficiency raccordance with	reflects State findings cited in 410 IAC 16.2.			FEB 2 4 2011		
F 272 SS=D	Quality review c Bartelt, RN 483.20, 483.20( ASSESSMENTS	ompleted 2/9/11 by Jennie b) COMPREHENSIVE S		<del>-</del> 272	LONG TERM CARE DIVISIO INDIANA STATE DEPARTMENT OF	N HEALTH	
LABORATOR	a comprehensiv	t conduct initially and periodically e, accurate, standardized OVIDER/SUPPLIER REPRESENTATIVE'S S		E	Administrato		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000474

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
. '		155596	B. WING		C ★ 02/04/2011
	ROVIDER OR SUPPLIEF	ING AND REHABILITATION		REET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 272	A facility must ma assessment of a specified by the Sinclude at least the Identification and Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well Physical functioni Continence; Disease diagnosis Dental and nutritic Skin conditions; Activity pursuit; Medications; Special treatment Discharge potenti Documentation of the additional assessimesident assessment of the system of the	ke a comprehensive resident's needs, using the RAI tate. The assessment must e following: demographic information; e; s; or patterns; -being; ng and structural problems; es and health conditions; onal status;	F 272	It is the policy of this facility initially and periodically cond comprehensive, accurate, a st ardized, reproducible assessme each resident's functional cape. Resident B was re-evaluated readmission to this facility on -11. A fall risk assessment we completed with a score indicating high risk. The care plan was ed and updated on 1-19-11 to new interventions of low bed mat at bedside on floor. New orders were also receive the doctor for a chair pressure a mobility alarm and a raised mattress. All were place in updated.	duct a and- nent of pacity.  where the pacity is a second of the pacity is a second of the pacity is a second of the pacity include with the pacity include with the pacity include a second of the pacity include with the pacity include a pacity include
	by: Based on intervier failed to ensure a thoroughly assess staff to the reside discontinued. This	ENT is not met as evidenced w and record review, the facility resident at risk of falls was sed before a device used to alert int's rising unassisted was s deficient practice affected 1 of were at risk of falls in a sample of		On 1-27-11 and 1-28-11 all recharts were reviewed for approand timely fall risk assessment. Those residents that triggered risk received an additional auappropriate interventions and plans.	ropriate nts. I as high dit for care
	o. (Hooldone in D)			On 1-27-11 and 1-28-11, nurse consisting of RN, LPN and Q	-

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		155596		B. WING		. C	
		193990				02/04	4/2011
NAME OF P	ROVIDER OR SUPPLIER	·	*.		REET ADDRESS, CITY, STATE, ZIP CODE		
LAKELA	ND SKILLED NURSIN	G AND REHABILITATION			00 N WILLIAMS ST		
	· · · · · · · · · · · · · · · · · · ·				NGOLA, IN 46703		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DÉFICIENCIES  MUST BE PRÈCEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 2	F2	272	79-		
	Findings include:				were re-educated on completi	_	
					risk assessments and forward	_	
	On 2/3/11 at 9:00 a.m., during the orientation tour, the ADON (Assistant Director of Nursing)				recommendations to the IDT	-	
					discontinuing any safety meas	sure or	
		#B had fallen in the facility and and and wrist fracture. The ADON			device.		
		#B was hospitalized after the			They were also re-educated the	nat the	
		the facility following a surgical			care plan must be updated and	l reflect	
	repair of the hip fracture but currently was in the				any changes for any new or d	iscon-	0
	hospital because a displaced.	screw in the hip had become			tinued intervention.	ļ	
	The endings of the second	- FD - ide of UD			A Fall committee was formed	that	
		of Resident #B was reviewed a.m. and indicated the resident			reviews any fall for root cause		
		facility on 12/3/10 for			change in risk level and to ad	•	
		ing a hospitalization for an			new interventions. All reside	· ·	
		peritonitis. The resident's			reviewed with IDT walking re	1	
		, but were not limited to,			the next business day after an		
		e, dementia, and osteoporosis. een residing in an assisted			Director of Nursing and/or Do	-	
	living facility prior to				will monitor during routine ro	_	
	in ing receiving prior to	no, appondiciae.			ensure that continued complia		
		ment, dated 12/3/10, indicated			obtained. This area will be re		
		high risk of falls and had					
	"intermittent confus	ion."		ĺ	5x week for one month, per 2		
	Admission physicial	n orders, dated 12/3/10,			report sheets, telephone order		
		alarm on @ (at) all times			fall reports, then weekly x4, t	ì	
	(check mark) q (eve				monthly through random aud	· ·	
					IDT rounds. Results of the au	1	.
		ated Occupational Therapy			will be reported monthly to th		
		/10, Physical Therapy on	•		Committee for review. The C	- 1	
	iziri io, and Speed	h Therapy on 12/13/10.	,		mittee responsible, to the Adr	:	
	Nursing notes date	d 12/8/10, indicated, "D/c			trator, will review audits for o	ontinued	
		ty alarm res (resident) uses			compliance.		
		ely to convey needs" There					
		ion Resident #B safety needs					
	were comprehensiv	alv accepted or that the		+		1	ł

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155596	B. WING		C 02/04/2011	
NAME OF P	ROVIDER OR SUPPLIER	133390	l s	TREET ADDRESS, CITY, STATE, ZIP CO		4/2011
LAKELAND SKILLED NURSING AND REHABILITATION				500 N WILLIAMS ST ANGOLA, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Physical or Occup consulted before t discontinued.  During interview o who had discontin Resident #B, indic confusion had cleacall light, was confuer to be more incompared to the more	ational Therapists were the mobility alarm was  n 2/3/11 at 1:30 p.m., LPN #10, ued the mobility alarm for ated she felt the resident's ared, the resident was using her tinent, and the family wanted lependent. LPN #10 indicated is discontinuing the mobility rapists.  plan, dated 12/10/10, indicated at risk of falls related to ication, diuretic medication,	F 27	72		
	awareness, deme A Social Services 12/27/10, indicate of 7 on the BIMS ( Status) indicating status impairment Physical Therapy 1/11/11 and 1/14/ required contact g ambulation due to indicated the resic precautions includ visual cues." The (patient) is attemp devices or assista  Occupational The 1/8/11 and 1/14/1	kinson's, poor safety ntia and weakness.  30 day summary, dated d the resident received a score (Brief Interview for Mental the resident had severe mental (0-7 severe impairment).  Summary notes, between 11, indicated the resident uard assist for safe transfer and unsteadiness. The summary lent was a fall risk and "safety le need for verbal, tactile and note further indicated "Pt ting to walk without assistive nce from caregivers"  rapy Summary notes between 1 indicated, "Patient impulsive s up from wheelchair to walk				

STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILD	DING		^	
		155596	B. WING		1	C 02/04/2011	
	ROVIDER OR SUPPLIER  ND SKILLED NURSI	NG AND REHABILITATION	s	TREET ADDRESS, CITY, STATE, ZIP ( 500 N WILLIAMS ST ANGOLA, IN 46703	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 272	Continued From p	age 4	F 27	2			
	through 1/14/11, in to demonstrate ab	Summary between 1/8/11 ndicated the resident was able ility to follow safety precautions ity (51 to 70% of the time) and impairment.					
	the resident was for of her room. The r her right hip and ri resident was sent	p.m., nursing notes indicated bund on the floor in the doorway esident complained of pain in ght wrist. Subsequently, the to the hospital and admitted the wrist and right hip.					
	Rehabilitation was #B's mobility alarm indicated Resident her balance was in assistance to transawareness. The Erecall having any in	p.m., the Director of interviewed about Resident in The Director of Rehabilitation if #B was getting stronger and improving but she still needed ofer and had no safety Director indicated she did not input when the alarm was she felt Resident #B should y alarm.					
	Nursing) indicated Team), including a #B and identified in 12/30/10 but they if 12/30/10 and no re The DON further in on 1/27/11 and 1/2 were to be done be mobility alarms or in Finally, the DON in met to evaluate the	ta.m., the DON (Director of the IDT (Interdisciplinary therapist, discussed Resident to new safety issues on the nad not met formally after the ew interventions were initiated to indicated staff were inserviced and fall risk assessments after the discontinuation of fall preventative measures. Indicated, after the fall, the IDT are effectiveness of the fall intions for all residents at risk for					

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· .		155596	B. WING		C * 02/04/2011	
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F 272	Continued From p	age 5	F 272	,		
	provided by the Do	nent Procedure, dated 10/10, ON, was reviewed on 2/4/11 at dicated, "3. Regularly review, te care plan effectiveness at ad	•			-
F 280 SS=D	3.1-31(a) 483.20(d)(3), 483. PARTICIPATE PL The resident has to incompetent or other incapacitated under participate in plant changes in care and A comprehensive within 7 days after comprehensive as interdisciplinary temphysician, a regist for the resident, and disciplines as deter and, to the extent the resident, the relegal representative.	care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's re; and periodically reviewed eam of qualified persons after	F 280	It is the policy of this facility develope a comprehensive car plan based on the comprehensive care plan based on the resident with input from the IDT, physician resident and family. Updates the care plan are completed by team of qualified persons after each assessment and review care plan.  Resident B was re-evaluated readmission to this facility of the completed with a score indicated high risk. The care plan was ed and updated on 1-19-11 to new interventions of low bed mat at bedside on floor.  New orders were also received the doctor for a chair pressur a mobility alarm and a raised	are asive ith n, s to by a er of the upon n 1-19 was ating review- include I with ed from e alarm,	* 2-4-11 5
	by:	NT is not met as evidenced vand record review, the facility		mattress. All were placed in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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•	ROVIDER OR SUPPLIEF	ING AND REHABILITATION	50	EET ADDRESS, CITY, STATE, ZIP CODE 00 N WILLIAMS ST NGOLA, IN 46703		
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F 280	updated when the get up unassisted supervised, fell ar This deficient prawho were at risk (Resident #B)  Findings include:  On 2/3/11 at 9:00 tour, the ADON (/indicated Resider had sustained a hindicated Resider fall and returned to repair of the hip fin hospital because displaced.  The clinical record on 2/3/11 at 10:00 was admitted to the rehabilitation follor appendectomy wild diagnoses include Parkinson's diseased.  The fall risk assess the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) q (expectation) and the resident was a "intermittent confidence mark) and the resident was a "intermi	the fall risk care plan was be resident began to attempt to all. The resident was not and fractured her hip and wrist. Citice affected 1 of 3 residents of falls in a sample of 3.  a.m., during the orientation Assistant Director of Nursing) at #B had fallen in the facility and hip and wrist fracture. The ADON at #B was hospitalized after the to the facility following a surgical racture but currently was in the a screw in the hip had become  d of Resident #B was reviewed a.m. and indicated the resident he facility on 12/3/10 for twing a hospitalization for an atthe peritonitis. The resident's ed but were not limited to, ase, dementia, and osteoporosis, been residing in an assisted to her appendicitis.  ssment, dated 12/3/10, indicated at high risk of falls and had usion."  ian orders, dated 12/3/10, as alarm on @ (at) all times	F 280	1-19-11 and the care plan was to include all interventions.  On 1-27-11 and 1-28-11 all recharts were reviewed for appand timely fall risk assessment. Those residents that triggered risk received an additional at appropriate interventions and plans.  On 1-27-11 and 1-28-11, nurconsisting of RN, LPN and Cowere re-educated on complet risk assessments and forward recommendations to the IDT discontinuing any safety meadevice. They were also re-educated to care plan must be updated an any changes for any new or continued intervention.  A Fall committee was formed reviews any fall for root cause change in risk level and to ach new interventions. All residence reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will monitor during routine reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will monitor during routine reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will monitor during routine reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will monitor during routine reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will monitor during routine reviewed with IDT walking in the next business day after an Director of Nursing and/or Existence will make the plant of the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and/or Existence will make the next business day after an Director of Nursing and the next business day after an Director of Nursing and the next business day after an Director of Nursing and the ne	esident propriate ents. I as high adit for a care esing staff QMA's sing fall ling prior to asure or that the ed reflect disconditions. I designee esignee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU COMPLE	
	1		A. BUILDING		G	c	
		155596	B. WII	VG		1	1/2011
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			5	REET ADDRESS, CITY, STATE, ZIP CODE 00 N WILLIAMS ST INGOLA, IN 46703		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	was started on 12/6 12/7/10, and Speed Nursing notes, date (discontinue) mobil call light appropriat was no documenta were comprehensive physical or occupationsulted before the discontinued.  The fall risk care pleased the resident was at psychotropic medic osteoporosis, Parki awareness, demended the forested the plan included the forested adequate light within encourage use of the keep call light within encourage use of the monitor unsteady ginstruct to avoid sullabs as ordered, assess toileting need provide verbal safe keep personal belokeep assistive deviwheelchair), wear clear and clear provide non-skid for Physical Therapy endocupational Therapy endocup	6/10, Physical Therapy on ch Therapy on 12/13/10.  ed 12/8/10, indicated, "D/c ity alarm res (resident) uses ely to convey needs" There tion Resident #B safety needs yely assessed or that the tional therapists were in mobility alarm was  an, dated 12/10/10, indicated risk of falls related to cation, diuretic medication, inson's, poor safety tia and weakness. The care following interventions: ghting, is of medication, in reach, call light, spills and clutter, that and balance, dden position changes, eds, ty cues, origings within reach, ces within easy reach: (walker, an eye wear,	F	280	ensure that continued complia obtained. This area will be re 5x week for one month, per 2 report sheet, telephone orders fall reports, then weekly x4, t monthly through random aud IDT rounds. Results of the arbe reported monthly to the QA mittee for review. The QA C responsible to the Administrate review audits for continued or	eviewed 4 hour 4, and hen its and udits will A Com- ommittee tor will	
	until 1/19/11, after	the resident returned from the					<u>.</u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLI	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			50	ET ADDRESS, CITY, STATE, ZIP COD O N WILLIAMS ST NGOLA, IN 46703		·	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		D BY FULL PREFIX (EACH (		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 280	Nursing notes indic On 1/4/11 at 8:30 pincreased indepenhelp in her room at On 1/11/10 at 8:35 walking in the hall.  Physical Therapy \$1/11/11 and 1/14/17 required contact grambulation due to indicated the reside precautions includivisual cues." The (patient) is attempted devices or assistant Occupational Ther 1/8/11 and 1/14/11 and frequently gets behind it with no as \$1/14/11, into demonstrate ab	cated the following: p.m., Resident #B was showing dence and was walking without and down the hall. p.m., resident was found to be without her wheel chair.  Summary notes, between 1, indicated the resident uard assist for safe transfer and unsteadiness. The summary ent was a fall risk and "safety e need for verbal, tactile and note further indicated, "Pt ting to walk without assistive nce from caregivers"  rapy Summary notes between I Findicated, "Patient impulsive s up from wheelchair to walk	F 280				
	the resident was for of her room. The re- her right hip and rig- resident was sent with a fractured rig On 2/3/11 at 11:30 Rehabilitation was	Impairment.  I p.m., nursing notes indicated bund on the floor in the doorway esident complained of pain in ght wrist. Subsequently, the to the hospital and admitted ht wrist and right hip.  I p.m., the Director of interviewed about Resident in The Director of Rehabilitation					

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F 280	indicated Resident her balance was in assistance to trans awareness. The Director indica any input when the	age 9  #B was getting stronger and inproving but she still needed sfer and had no safety  ated she did not recall having alarm was discontinued and B should have had a mobility	F 280			
	with Resident #B, CNA #10 indicated without help and s herself but she cor	o.m., CNA #11, who worked was interviewed about the fall. I Resident #B would get up he was told not to get up by attinued to do it. The CNA ent wanted to go home and mes.			· · ·	
e e e e e e e e e e e e e e e e e e e	duty when Resider LPN indicated the she went to pass or received a call from Resident #B was of her room. The resided, and the reshospital. LPN #12	o.m., LPN #12, who was on the fell, was interviewed. The resident #B was in bed when drinks in the dining room. She in the CNA, went to check and on the floor in the door way of dent had pain, EMS was ident was transported to the indicated she had "caught" up without assistance twice for help.				
	found the resident interviewed. CNA in the resident was at the Resident #B's roor the corner, Resident #B's roor the doorway. The worked with Resident Resid	o.m., CNA #13, who initially on the floor on 1/14/11, was #13 indicated she saw Resident he fall. The CNA indicated a enurses station pointing toward in and when she went around int #B was lying on the floor in CNA indicated she had not ent #B and had no first hand Resident #B getting up on her				

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÷	ROVIDER OR SUPPLIER ND SKILLED NURSI	NG AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Om 2/4/11 at 10:30 Director was intervalled by the provided by the DON in met to evaluate the prevention interver falls.  The Fall Managem provided by the DON 1:30 a.m., and increvise, and evaluate an injuries"	a.m., the Rehabilitation viewed about Resident #B's fall. ated Resident #B was not safe ring alone. The Director ad to the family on 1/14/11, concerns. She indicated she ing nurse (LPN #12) that the safe" transferring herself and "  a.m., the DON (Director of the IDT (interdisciplinary therapist, discussed Resident to new safety issues on had not met formally after ew interventions were initiated. Indicated staff were inserviced as and fall risk assessments after the discontinuation of fall preventative measures. Indicated, after the fall, the IDT are effectiveness of the fall intions for all residents at risk for the procedure, dated 10/10, DN, was reviewed on 2/4/11 at dicated "3. Regularly review, the care plan effectiveness at discontinuation of safe and the safe and the safe and the safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe and safe are plan effectiveness at discontinuation of safe are plan effectivenes at the safe are plan effectiveness at the safe are plan effecti	F 28	0			
•		lates to Complaint IN00085379.					
F 323 SS=G		F ACCIDENT RVISION/DEVICES	F 32	3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLEȚED		
			A. BUILDIN	IG	c *	
•		155596	B. WING		02/04/2011	
-	NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			REET ADDRESS, CITY, STATE, ZIP CODE 100 N WILLIAMS ST ANGOLA, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID. PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION	
F 323	environment remain as is possible; and	ge 11 sure that the resident as free of accident hazards each resident receives on and assistance devices to	F 323	It is the policy of this facility ensure that the resident environment remains as free from according dent hazards as possible: that each resident receives adequate supervision and assistance devices to prevent accidents.	on- ci- ate	
	by: Based on interview failed to ensure a re thoroughly assesse staff to the resident discontinued, and facare plan was updato attempt to get up not supervised, fell wrist. This deficient	and record review, the facility esident at risk of falls was d before a device used to alert 's rising unassisted was ailed to assure the fall risk sted when the resident began unassisted. The resident was and fractured her hip and t practice affected 1 of 3 at risk of falls in a sample of		Resident B was re-evaluated readmission to this facility or -11. A fall risk assessment we completed with a score indicating high risk. The care plan was ed and updated on 1-19-11 to new interventions of low bed mat at bedside on floor. New orders were also receive the doctor for a chair pressure a mobility alarm and a raised mattress. All were placed in 1-19-11 and the care plan was to include all interventions.	n 1-19 yas ating review- o include with ed from e alarm, edge use on	
	tour, the ADON (As indicated Resident had sustained a hip indicated Resident fall and returned to repair of the hip fraction.	.m., during the orientation sistant Director of Nursing) #B had fallen in the facility and and wrist fracture. The ADON #B was hospitalized after the the facility following a surgical cture but currently was in the screw in the hip had become		On 1-27-11 and 1-28-11 all recharts were reviewed for apprand timely fall risk assessment Those residents that triggered risk received an additional auappropriate interventions and plans.	ropriate onts. I as high odit for	
	on 2/3/11 at 10:00 a	of Resident #B was reviewed a.m., and indicated the ed to the facility on 12/3/10 for		On 1-27-11 and 1-28-11, nurse consisting of RN, LPN and Q		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
						C 04/2011	
	PROVIDER OR SUPPLIER	IG AND REHABILITATION		REET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	appendectomy with diagnoses included Parkinson's disease. The resident had be living facility prior to The fall risk assess the resident was at "intermittent confus Admission physicia indicated, "Mobility (check mark) q (every Therapy notes indicated, "Mobility (check mark) q (e	ing a hospitalization for an peritonitis. The resident's but were not limited to, e, dementia, and osteoporosis. Deen residing in an assisted her appendicitis.  ment, dated 12/3/10, indicated high risk of falls and had ion."  In orders, dated 12/3/10, alarm on @ (at) all times ery) shift."  Determined a compational Therapy on the Therapy on 12/13/10.  In d 12/8/10, indicated, "D/c ty alarm res (resident) uses ely to convey needs" There it ion Resident #B's safety enensively assessed or that upational Therapists were ely mobility alarm was  2/3/11 at 1:30 p.m., LPN #10, ed the mobility alarm for the she felt the resident's ed, the resident was using her nent, and the family wanted pendent. LPN #10 indicated discontinuing the mobility	F 323	were re-educated on complete risk assessments and forward recommendations to the IDT discontinuing any safety mean device.  They were also re-educated the care plan must be updated and any changes for any new or detinued intervention.  A Fall committee was formed reviews any fall for root cause change in risk level and to addinterventions. All residents are reviewed with IDT walking in the next business day after an Director of Nursing and/or Direct	hat the ad reflect discon- d that sed, any ld any new are cound by fall. Designee counds to ance is eviewed 24 hours and then lits and udits will A Com-Committee ator, will	,	

NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION    CAULD   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 323   Continued From page 13	155596						t	<u> </u>	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 13  psychotropic medication, diuretic medication, osteoporosis, Parkinson's, poor safety awareness, dementia and weakness. The care plan included the following interventions: provide adequate lighting, monitor side effects of medication, keep call light within reach, encourage use of call light, keep floors free of spills and clutter, monitor unsteady gait and balance. instruct to avoid sudden position changes, labs as ordered, assess toileting needs, provide verbal safety cues, keep personal belongings within reach, keep assistive devices within easy reach: (walker, wheelchair),					5	500 N WILLIAMS ST			
psychotropic medication, diuretic medication, osteoporosis, Parkinson's, poor safety awareness, dementia and weakness. The care plan included the following interventions: provide adequate lighting, monitor side effects of medication, keep call light within reach, encourage use of call light, keep floors free of spills and clutter, monitor unsteady gait and balance. instruct to avoid sudden position changes, labs as ordered, assess toileting needs, provide verbal safety cues, keep personal belongings within reach, keep assistive devices within easy reach: (walker, wheelchair),	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION	
wear clear and clean eye wear, provide non-skid foot wear, Physical Therapy evaluation and treatment.  No additional interventions were implemented until 1/19/11, after the resident returned from the hospital, following the repair of her hip fracture.  A Social Services 30 day summary, dated 12/27/10, indicated the resident received a score of 7 on the BIMS (Brief Interview for Mental Status) indicating the resident had severe mental status impairment (0-7 severe impairment).  Nursing notes indicated the following: On 1/4/11 at 8:30 p.m., Resident #B was showing increased independence and was walking without help in her room and down the hall. On 1/11/10 at 8:35 p.m., resident was found to be walking in the hall without her wheel chair.	F 323	psychotropic medic osteoporosis, Parki awareness, demen plan included the form plan included the form provide adequate limonitor side effects keep call light within encourage use of continuous free of monitor unsteady grant in the provide verbal safe keep personal belokeep assistive deviwheelchair), wear clear and clear provide non-skid for Physical Therapy error occupational Theration No additional interventil 1/19/11, after the hospital, following the status impairment of the Nursing notes indic On 1/4/11 at 8:30 princreased independently in her room ar On 1/11/10 at 8:35	cation, diuretic medication, inson's, poor safety tia and weakness. The care ollowing interventions: ghting, sof medication, in reach, call light, spills and clutter, lait and balance. dden position changes, eds, fly cues, angings within reach, ces within easy reach: (walker, ean eye wear, evaluation and treatment, and eapy evaluation and treatment.  The resident returned from the the repair of her hip fracture.  30 day summary, dated the resident received a score of the resident received a score of the resident had severe mental (0-7 severe impairment).  The stated the following:  The cated the following:  T	F	323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED			
		155596	B. WING			C 4/2011		
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703					
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F 323	Physical Therapy 1/11/11 and 1/14/required contact (ambulation due to indicated the resign precautions including visual cues." The (patient) is attempted devices or assistated occupational The 1/8/11 and 1/14/1 and frequently gebehind it with no a Speech Therapy through 1/14/11,	Summary notes, between 11, indicated the resident guard assist for safe transfer and o unsteadiness. The summary dent was a fall risk and "safety de need for verbal, tactile and note further indicated "Pt oting to walk without assistive ance from caregivers" erapy Summary notes between 1 indicated, "Patient impulsive ts up from wheelchair to walk assistance."  Summary between 1/8/11 indicated the resident was able	F 323					
	to demonstrate all with moderate ab had mild cognitive.  On 1/14/11 at 5:3 the resident was of her room, the rher right hip and resident was sent with a fractured right hip and a fractured right hip and a fractured right hip and indicated Resider her balance was assistance to trar awareness. The I recall having any	bility to follow safety precautions ility (51 to 70% of the time) and eximpairment.  O p.m., nursing notes indicated found on the floor in the doorway resident complained of pain in right wrist. Subsequently, the state to the hospital and admitted ght wrist and right hip.  O p.m., the Director of sinterviewed about Resident m. The Director of Rehabilitation of the was getting stronger and improving but she still needed insfer and had no safety Director indicated she did not input when the alarm was she felt Resident #B should						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155596	B. WII	NG		1	C 4/2011
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703				
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F 323	On 2/3/11 at 1:20 with Resident #B, CNA #10 indicated without help and sherself but she co	p.m., CNA #11, who worked was interviewed about the fall. It Resident #B would get up he was told not to get up by ntinued to do it. The CNA lent wanted to go home and	F:	323			
	duty when Reside LPN indicated the she went to pass or received a call from Resident #B was of her room. The resided, and the resided, and the resided LPN #12	p.m., LPN #12, who was on nt #B fell, was interviewed. The resident #B was in bed when drinks in the dining room. She m the CNA, went to check and on the floor in the door way of ident had pain, EMS was sident was transported to the principal indicated she had "caught" grup without assistance twice I for help.					
	found the resident interviewed. CNA #B in bed before t resident was at th Resident #B's roo the corner, Resident her doorway. The worked with Resident	p.m., CNA #13, who initially on the floor on 1/14/11, was #13 indicated she saw Resident he fall. The CNA indicated a enurses station pointing toward mand when she went around ent #B was lying on the floor in CNA indicated she had not lent #B and had no first hand Resident #B getting up on her					
·	Director was inter The Director indic walking or transfe indicated she talke about their safety	D a.m., the Rehabilitation viewed about Resident #B's fall. ated Resident #B was not safe rring alone. The Director ed to the family, on 1/14/11, concerns. She indicated she ing nurse (LPN #12) that the					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED C	
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155596			D. 11110			02/04/2011		
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page 16 resident was "not safe" transferring herself and "needed watching." The Director indicated she did not document the conversations with the family or		F 3	23				
	the nurse.  On 2/4/11 at 11:00 Nursing) indicated Team), including a #B and identified n 12/30/10 but they h 12/30/10 and no no The DON indicated before 1/14/11. The were inserviced on risk assessments of discontinuation of preventative meas indicated, after the the effectiveness of interventions for all	a.m., the DON (Director of the IDT (Interdisciplinary therapist, discussed Resident o new safety issues on had not met formally after ew interventions were initiated. If the resident had no falls he DON further indicated staff in 1/27/11 and 1/28/11 and fall were to be done before the mobility alarms or fall ures. Finally, the DON fall, the IDT met to evaluate of the fall prevention.						
	provided by the DC 11:30 a.m., and ind revise, and evalual minimizing falls an injuries"	nent Procedure, dated 10/10, DN, was reviewed on 2/4/11 at dicated, "3. Regularly review, the care plan effectiveness at d				·		
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	3.1-45(a)(2)							
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